

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013217

FILED MAY 1 1959 Registration District No. 147 Primary Registration District No. 1002 STATE FILE NUMBER 1821 Registrar's No.

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-57 1

1. PLACE OF DEATH a. COUNTY JACKSON			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY JACKSON		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS City			c. CITY OR TOWN KANSAS City		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1012 W. 79 ST.			d. STREET ADDRESS (If outside, give location) 1012 W. 79 ST.		
3. NAME OF DECEASED (Type or print) First Middle Last James Joseph Cassidy			4. DATE OF DEATH Month Day Year April 10, 1959		
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1904		9. AGE (In years last birthday) 54
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Plumber		10b. KIND OF BUSINESS OR INDUSTRY Plumbing		11. BIRTHPLACE (City and state or country) KANSAS City, Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Michael Cassidy		13b. MOTHER'S MAIDEN NAME BARBARA OXLER	
14. NAME OF HUSBAND OR WIFE MARY A. Cassidy		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 496-09-3888	
17. INFORMANT MARY A. Cassidy		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor Pulmonale DUE TO (b) Pulmonary Fibrosis DUE TO (c) Unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 525X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from Death occurred at Jan 1955 to April 10, 1959 and last saw him alive on April 10, 1959 on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE W. J. Stelmach (Degree or title) MD		22b. ADDRESS 7951 State Line		22c. DATE SIGNED 4/11/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 13, 1959		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVE Cemetery	
23d. LOCATION (City, town, or county) (State) KANSAS City Missouri		24. FUNERAL DIRECTOR Muehlebach		25. DATE RECD. BY LOCAL REG. 4-11-59	
26. REGISTRAR'S SIGNATURE Heva Minshall					

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

W. J. Stelmach

7951 Skidline.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed

R. S. Nichols

Licensed Embalmer No. *4997*

P. O. Address *H. C. Miss*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.